PREFERRED CARE NETWORK
A UnitedHealthcare Company

INSTRUCTIONS

1. Complete all the sections below, and sign where indicated.
   - ✓ Along with the claim, submit COPIES of:
   - ✓ CMS-1500 or UB04
   - ✓ Any medical records or documentation that supports the appeal
2. Relevant sections of the National Correct Coding Initiative (CCI) or other coding support you relied upon IF the dispute concerns the disposition of billing codes.
3. Submit form and supporting documentation to the appropriate address below:

Questions? We are here to help! Call the Provider Services Line 1-866-724-9334, Monday-Friday, 8 a.m.-8 p.m. ET

Medical Care - Part C

- UHC MedicareMax Medicare Advantage FL-0028 (HMO)
- UHC MedicareMax Medicare Advantage FL-0029 (HMO)
- UHC MedicareMax Complete Care FL-0030 (HMO C-SNP)

Preferred Care Network
Appeals & Grievance Department
P.O Box 6106, MS CA124-0157
Cypress, CA 90630-0016

Medical Care - Part C

- UHC MedicareMax Medicare Advantage FL-D004 (HMO D-SNP)

Preferred Care Network
Appeals & Grievance Department
P.O Box 6106, MS CA124-0187
Cypress, CA 90630-0016

Prescription Drugs - Part D

- All plans

Preferred Care Network
Appeals & Grievance Department
P.O Box 6106, MS CA124-0197
Cypress, CA 90630-0016

PHYSICIAN/HEALTH CARE PROFESSIONAL INFORMATION:

Tax Identification Number (TIN): _____ Phone Number: _____

Provider Name: _____

Facility/Group Name: _____

Street Address: _____

Contact Name: _____ Email: _____

PATIENT INFORMATION:

Member Name: _____ Member ID: _____ Date of Birth: _____

Address: _____

APPEAL NFORMATION:

I wish to submit an Appeal to Preferred Care Partners regarding the denial of the following:

Claim/Authorization: _____ Date of Service: _____

Denial Reason: _____ Total Charges (Claim Appeal): _____

Physician providing service (Authorization Appeal): _____

Reason for reconsideration: _____

_____

Signature _____ Date _____